Pregnancy Surveillance Program

Occupational Health Pregnancy Surveillance Questionnaire – Part I

TO BE COMPLETED BY EMPLOYEE

Name: _____ Age: _____ Rank: _____

MOS/Position: _____ SSN: _____

Supervisor's Name: _____ Unit: _____

Duty Phone: _____ Home Phone: _____ BLDG. #: _____

Environmental Factors in your work area: Check any items below that you perform as part of your duties or any item that you are exposed to in your work environment.

Duration of work (hours per week): _____

Have you been reassigned due to pregnancy? ☐ YES ☐ NO

Work Area: ☐ Motor Pool ☐ Indoor Firing Range ☐ Arms Room ☐ Hospital or Clinic

☐ Other (please specify): _____.

Description of work activities:

Work Exposures or duties: Please check all that apply to you.

☐ Vehicle Sanding ☐ Spray Painting ☐ Parts Cleaning/Degreasing

☐ Fuel Handling ☐ Aviation Mechanics ☐ Photo Developing

☐ Driver of Vehicle over 1 ¼ ton ☐ Prolonged lifting over 25 pounds ☐ Working at Heights

☐ Prolonged Standing (# of hours): _____ ☐ Respirator Use

☐ Welding (please specify) ☐ Excessive Vibrations ☐ Other Industrial Operations

☐ Cold Extremes ☐ Heat Extremes ☐ Non-ionizing Radiation

☐ Ionizing Radiation ☐ Pesticides ☐ Anesthetic Gases (hospital/clinic work)

☐ Chemotherapeutic Agents (i.e. hospital work) ☐ Communicable Diseases (i.e. hospital/clinic work) ☐ Blood Products (hospital/clinic/sanitation work)

☐ Loud Noise/Vibrations ☐ Chemicals (specify): _____

☐ Frequent lifting/bending (specify weight lifted and frequency _____

List other work place exposures you consider hazardous:

What safety equipment is required in the course of your duties?

☐ Respirator

What kind? _____How often used? _____

☐ Garments

What kind? _____How often used? _____

☐ Belts/Harness

What kind? _____How often used? _____

☐ Other - Specify: _____

Health History:

Significant OB History:

Chronic Disease: *Do you now, or have you had in the past:*	Yes	No
1. History of heart problems, chest pain, or stroke	☐	☐
2. Increased blood pressure	☐	☐
3. Any Chronic Illness	☐	☐
specify: _____		
4. Difficulty with physical exercise	☐	☐
5. Advice from physician not to exercise	☐	☐
6. Recent surgery (last 12 months)	☐	☐
7. History of breathing or lung problems	☐	☐
8. Seizures, Convulsions, Epilepsy, Fainting, Dizziness	☐	☐
9. Bleeding Disorder, Anemia, Bleeding Tendency	☐	☐
10. Liver Disease (Jaundice, Hepatitis)	☐	☐
11. Kidney Disease	☐	☐
12. Muscle, joint, or back disorder	☐	☐
13. Any previous injury still affecting you	☐	☐
Specify: _____		
14. Diabetes or thyroid condition	☐	☐
15. Cigarette smoking habit	☐	☐
16. Obesity (more than 20% over ideal body weight)	☐	☐
17. Increased blood cholesterol	☐	☐
18. History of heart problems in immediate family	☐	☐

19. Autoimmune disorder i.e. Lupus, Graves, HIV ☐ ☐
20. Other illness: ☐ ☐
    Specify: _____

Major Illnesses or surgery, with dates:

Allergies:

History of Illness in Family:

Household Exposures:

List any hobbies, household cleaning compounds, animals or other activities that you perform which might expose you to hazards:

Occupational Health Pregnancy Surveillance Questionnaire – Part II

TO BE COMPLETED BY OCCUPATIONAL HEALTH PERSONNEL

Date Questionnaire Received:

OB History: Gravida _____ Para _____ EDC_____

Previous pregnancy complication to include any miscarriages, spontaneous abortions:

Worksite visit required? ☐ YES ☐ NO

If yes, the following questions must be completed. If no, Provider simply needs to sign this form.

Occupational Health Pregnancy surveillance

Date worksite visit conducted: _____

Description of worksite:

Potential exposures: (Note whether controlled or uncontrolled risks)

Is consultation for Industrial Hygiene or IH sampling to establish possible exposure or determine exposure levels needed? (specify)

Recommendations: (Include recommendations for modifications, job reassignment, education, etc.)

NAME: _____ SSN: _____

DOB: _____ Rank: _____ UNIT: _____